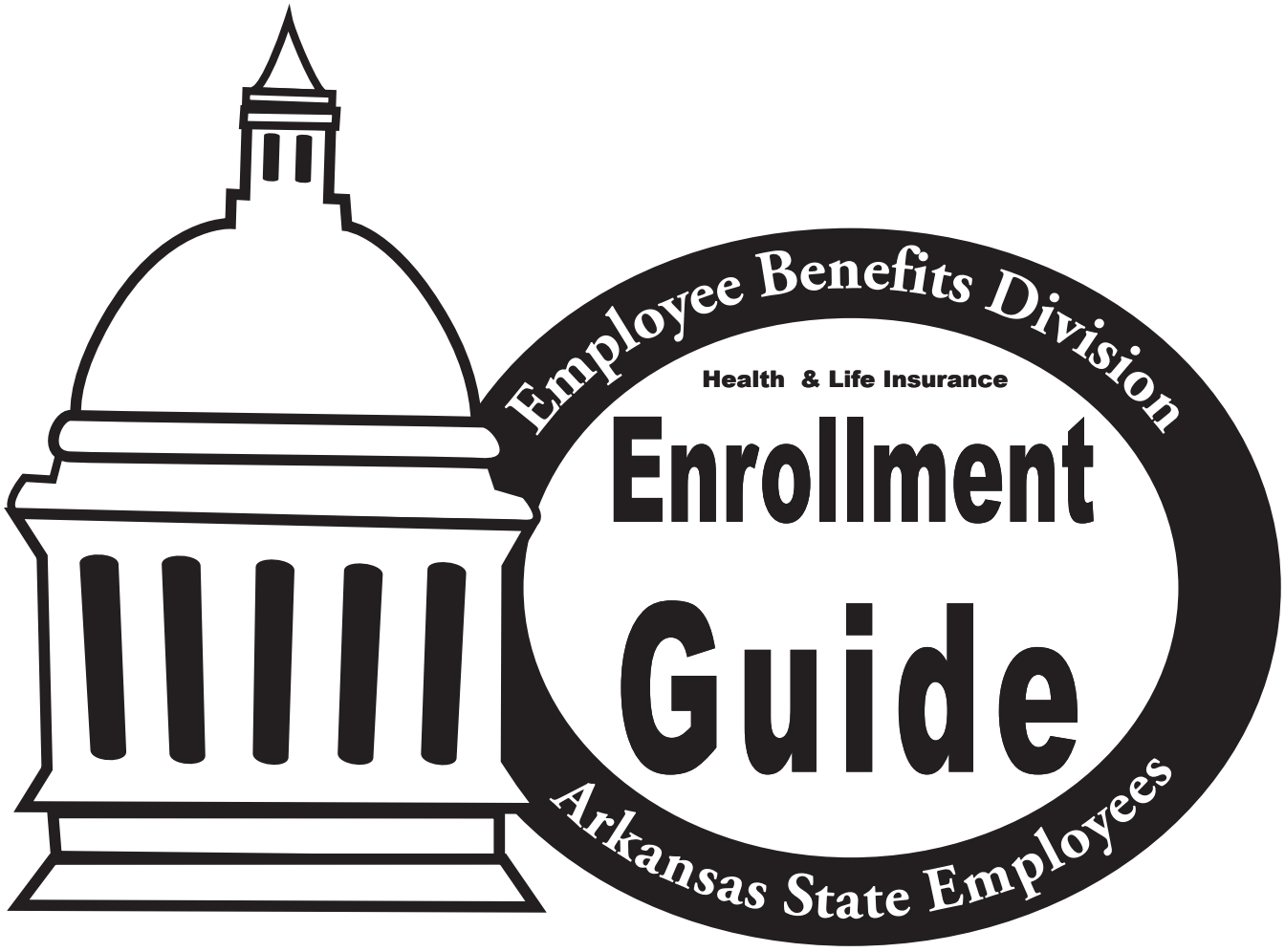
EBD



Enrollment Forms & Rate Information Inside!

Please keep as a reference throughout the plan year.

Web: http://www.state.ar.us/dfa/ebd | Email: AskEBD@dfa.state.ar.us

Contents - TELL ME WHAT I NEED TO KNOW!

ARE THERE ANY PLAN CHANGES FOR THE UPCOMING PLAN YEAR?

YES! And the changes are positive for you!

- Prescription Drug Benefits and Co-payments Remain the Same: $10 Generic, $25 Preferred/Formulary, and $50 Non-Preferred/Non-Formulary Reminder: as of May 1, 2003, prescriptions ordered through the Pilot Mail Order program are subject to the same co-pay structure as retail prescriptions – three (3) co-pays for up to a 102 day supply. Also, you can now receive a three month supply of the same maintenance prescription drugs from your local pharmacy for the same three (3) co-pays.

- Female members of QualChoice plans are no longer required to designate a separate OB/GYN specialist as a second Primary Care Physician (PCP). Members can continue to go to an Ob/Gyn directly, without a PCP referral, as long as the OB/GYN is in the QualChoice network. This practice has been in place for some time in the Health Advantage network.

- The annual benefit for prosthetics has been increased to $15,000.

- Effective January 1, 2004, the Employee Benefits Division will be the COBRA plan Administrator.

- Effective January 1, 2004, routine care for dependent pregnancy will no longer be a plan exclusion.

NO INSURANCE CARRIER OR PLAN OPTION CHANGES. SEE PAGES 12-17 FOR SUMMARY OF PLAN OPTIONS. FURTHER DETAILS ABOUT PLAN INCLUSIONS, LIMITATIONS AND EXCLUSIONS ARE CONTAINED IN THE SUMMARY PLAN DESCRIPTION (SPD) WHICH CAN BE OBTAINED FROM THE EMPLOYEE BENEFITS DIVISION.

Who is EBD?

State of Arkansas
Department of Finance and Administration

Employee Benefits Division

The mission of the Employee Benefits Division is to manage the group health and life insurance programs and other select benefit programs for active and retired state and public school employees; and to build quality programs that operate in an efficient and effective manner to ensure responsive customer service, promote product education, affordability and accessibility.

2003-2004
EMPLOYEE BENEFITS DIVISION - EMPLOYEE/JOB DUTIES

501-682-9656 1-877-815-1017

Administration

Sharon Dickerson	Executive Director
Peggy D'Agostino	Business Controller II
Tracy Spears	Receptionist
Pat Minyard	Administrative Assistant

Accounting

Kimberly May	Chief Fiscal Officer
Bill Anderson	Accounts Receivable Supervisor
Margaret Bryant	Cash Receipts & Billing Specialist
Rhonda Roberts	Accounts Payable Supervisor
Amy Pinkerston	Accounts Payable Specialist
Amy Tustison	Accounting Supervisor
Gloria Lovelace	Cash Management & Reconciliation Specialist
Andy Kukura	Ledger Accountant Supervisor
Judy Everett	Collections Supervisor

Communications

Ashli Davis	Communications Director

Medical Quality Compliance

Susan Bumpas, RN	Medical Quality Compliance Manager
Dee Moran, RN	Compliance Officer
Kathy Johnson	Auditor Supervisor
Laurie Fowler	Member Advocate
Vito Chiechi	Member Advocate
Janisa Hooks	Member Advocate

Operations

George Platt	Operations Manager
Louise Mann	Retirement Manager
Stella Greene	Business Administration Analyst
Kristi Vinyard	Benefits Specialist
Shana Cotton	Retirement Specialist
Liz Holland	Retirement Specialist
Andy Cains	Technical Specialist
Donna Cook	Technical Manager
Paige Harrington	Media Technician

Privacy/Security

Bob Sterling	Privacy/Security Officer

WHO CAN HELP ME?

HEALTH INSURANCE CARRIERS

Arkansas Blue Cross & Blue Shield (PPO Plan)
P. O. Box 2181
Little Rock, AR 72203
Toll-Free..... (800) 482-8416
Local Office ..... (501) 378-2437
E-mail ..... stateemployees@arkbluecross.com
Web site address:.....www.arkbluecross.com

Health Advantage (HMO and POS plans)
P. O. Box 8069
Little Rock, AR 72203
Toll-Free..... (800) 482-8416
Local Office ..... (501) 378-2437
E-mail.....stateemployees@arkbluecross.com
Web site address:.....www.healthadvantage-hmo.com

QualChoice/QCA (HMO and POS plans)
10825 Financial Centre Parkway, Suite 400
Little Rock, AR 72211
Toll-Free..... (800) 782-5246
Local Office ..... (501) 228-7111
E-mail…….Select “Contact Us” button on website
Web site address:.....www.qcark.com

PRESCRIPTION COVERAGE

Advance PCS, Inc.
750 West John Carpenter Freeway, Suite 1200
Irving, TX 75039
Customer Service..... (877) 456-9586
Web site……..http://ar.advancerx.com

BASIC LIFE INSURANCE

USAble Life
320 West Capitol, Suite 700
P.O. Box 1650
Little Rock, AR 72203
Toll-Free Customer Service..... (800) 370-5856
Toll-Free Life Claims..... (800) 648-0271
Local Office ..... (501) 375-7200
Web address……www.usablelife.com

BEHAVIORAL HEALTH, MENTAL HEALTH, SUBSTANCE ABUSE & StarEAP

Corphealth / STAR EAP
1701 Centerview Dr., Suite 101, Little Rock, AR 72211
Toll free 1-866-378-1645
Website:…….....….www.corphealth.com

Employee Benefits Division will administer COBRA effective January 1, 2004

BENEFIT INFORMATION and ASSISTANCE

Employee Benefits Division
P.O. Box 15610
Little Rock, AR 72231-5610
Toll-Free.....(877) 815-1017
Local Office.....(501) 682-9656
Web site address:…….....:www.accessarkansas.org/dfa/ebd
General Email Address……AskEBD@dfa.state.ar.us

What are my rights?

The following four pages contain the Notice of Privacy Practices and the Authorization for Release of Health Information Form. These are for your reference and use as needed.

Notice of Privacy Practices

From the State of Arkansas

Department of Finance & Administration

Employee Benefit Division

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

Employee Benefits Division (EBD) is responsible for managing health benefits for the State of Arkansas and the Public State Employees. As a group health plan, EBD is required to secure the privacy of protected health information. The Notice of Privacy Practices describes the types of information, its uses and disclosures and your rights regarding that information.

"Protected health information," (PHI) means information that is individually identifiable and is protected by privacy regulations. For example, information regarding the health care treatment, payment or operations that can identify you or your dependents. This information is obtained from enrollment forms for health care coverage, surveys, healthcare claims, specialist referrals, your medical records and other sources. You might provide protected health information by telephone, fax, letter or e-mail. Other sources of protected health information include but are not limited to, healthcare providers, such as **insurance administrators, network providers, claims processors** (hereafter referred to as business partners or affiliates). **When used with health related information, any of the following would be considered protected health information**:

- Marital status
- Name, address, and date of birth
- Information regarding dependents
- Gender
- Social Security Number
- Other similar information that relates to past, present or future medical care

Disclosures of protected health information not requiring authorization

The law allows the use and disclosure of protected health information without the authorization of the individual for the purpose of treatment, payment, and/or health care operations, which includes, but is not limited to:

- Treatment of a health condition
- Business planning and development
- Coordination of benefits
- Enrollment into the group health plan
- Eligibility for coverage issues
- Complaint review
- Regulatory review and legal compliance
- Payment for treatment
- Claims administration
- Insurance underwriting
- Premium billing
- Payment of claims
- Appeals review

Uses and disclosures for treatment: Your protected health information will be obtained from or disclosed to health care providers involved in your, or your dependents treatment.

Uses and disclosures for payment: Your protected health information will be obtained from and disclosed to individuals involved in your treatment for purposes of payment. Your protected health information may be shared with persons involved in utilization review, or other claims processing.

Uses and disclosures for health care operations: Your protected health information will be used and disclosed for plan operations including but not limited to underwriting, premium rating, auditing, and business planning. In order to ensure the privacy of your protected health information, EBD has developed privacy policies and procedures. During the normal course of business, EBD may share this information with its business partners or affiliates that have signed a contract specifying their compliance with EBD's privacy policies.

NOTE: Only the minimum necessary amount of information to complete the tasks listed below will be disclosed.

Disclosures of personal health information requiring authorization

In all situations, other than outlined above, EBD will ask for your authorization to use or disclose your protected health information. EBD will use or disclose information in these circumstances pursuant to the specific purpose contained in your authorization.

- Usually, only the person to whom the protected health information pertains may make authorization.
- In some circumstances, authorization may be obtained from a person representing your interests (such as in the case where you may be incapacitated and unable to make an informed authorization) or in emergency situations where authorization would be impractical to obtain.
- Any 3rd party acting as your advocate (for example, a family member, your employer or your elected official) would require an authorization

Forms

Forms may be obtained from EBD, Forms are:

• Authorization for Release of Information • Revoking Authorization for Release of Information

Your Rights

- You have the right to review and copy your protected health information maintained by EBD. If you require a copy of PHI the first request will be provided to you at no cost. A reasonable fee will be charged for shipping additional or subsequent copies.
- You can request a copy of the Notice of Privacy Practices by EBD.
- You have the right to request an accounting, or list, of non-routine disclosures of your protected health information by EBD as of the compliance date. This request must be made in writing.
- You have the right to request a restriction on the protected health information that may be used and/or disclosed. You have the right to request that communications regarding your protected health information from EBD be made at a certain time or location. This request must be in writing and EBD reserves the right to refuse the restriction.
- You have the right to receive confidential communication of PHI at alternate locations and by alternate means.

If you believe your privacy rights have been violated, you have the right to register a complaint with EBD's Privacy Officer:

EBD Privacy Officer
P.O. Box 15610
Little Rock, AR 72231
(501) 682-9656

Or you can send your complaint to the Secretary of Health and Human Services:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

To e-mail the HHS Secretary or other Department officials, send your message to: HHS.Mail@hhs.gov.

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Under the HIPAA regulations and guidelines, there can be no retaliation for filing a complaint.

Changes to Privacy Practices

If EBD changes its privacy policies and procedures, an updated Notice of Privacy Practices will be provided to you. Additional information, additional examples and up-to-date privacy notices are maintained on the EBD website at http://www.accessarkansas.org/dfa/ebd.

This notice became effective on April 14, 2003.

2000-d-1

STATE OF ARKANSAS
Department of Finance
and Administration

EBD
Employee Benefits Division
Post Office Box 15610
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-1168 http://www.state.ar.us/dfa/ebd

Authorization for Release of Health Information

Health Plan Participant: _____

Home Address: _____

_____

School / Agency: _____

I authorize the use or disclosure of the above-named individual's health information as described below:

The following individuals or organizations are authorized to make the disclosure:
(School Business Official, Agency Representative, etc.)

_____ _____

The type and amount of information to be used or disclosed is as follows:
(check off appropriate item(s), and include other information, where indicated)

☐ Problem List
☐ Medication List
☐ List of allergies
☐ Immunization Record
☐ Most recent history and physical
☐ Most recent discharge summary
☐ Consultation reports from (please supply doctor's names) _____
☐ Laboratory results from _____ (date) to _____ (date)
☐ Entire record from _____ (date) to _____ (date)
☐ Other; please describe: _____
_____

This information may be disclosed to, and used by, the following individuals or organizations: *(providers, spouse, friends, etc.)*

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

See reverse side.

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

By my signature below, I authorize disclosures to and by EBD.

This information is being disclosed for the following purpose: _____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the EBD Privacy Officer (on the header address.) I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

If I fail to specify an expiration date, event or condition, this authorization will expire in twelve (12) months from the date of this signing.

I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may be protected by federal privacy regulations.

I understand that I need not sign this form in order to ensure health care treatment, payment enrollment in my health plan, or eligibility for benefits.

_____ _____

Signature of Healthcare Participant or Legal Representative Date

_____

If signed by legal representative or dependent, print relationship

_____ _____

Signature of Witness Date

I understand that the information in my health record may include information relating to sexually transmitted disease, behavioral or mental health services and treatment for alcohol and drug abuse.

What Are My Plan Choices?

WHAT ARE MY PLAN CHOICES?

Please refer to the Summary Plan Descriptions, available from EBD, for more details. Also see maps in this section indicating in-network hospitals for each provider. Please refer to carrier websites or customer service centers for the most current provider information.

Health Maintenance Organization (HMO) offered by:

*** QualChoice of Arkansas**
*** Health Advantage**
Benefits are the same no matter which carrier is selected.

Participants must select an in-network Primary Care Physician (PCP) to oversee all care.
Out of network physician visits or services are not covered.

No deductibles to meet.
$20 co-pay for PCP visit
$25 co-pay for in-network Specialist visit
$100 co-pay for outpatient treatment or surgery with 10% co-insurance for lab work

Out-of-pocket maximums are $1,000 per person or $1,500 per family not including co-pays. Some services such as lab work, home health visits, therapy sessions, etc. carry a 10% co-insurance. The out of pocket maximum is reached by the sum of those co-insurance amounts within the plan year. When the out-of-pocket maximum is reached, no further co-insurance amounts will be required that year. Co-pays will still be charged.

OR

Point of Service (POS) plan offered by:

*** QualChoice of Arkansas**
*** Health Advantage**
Benefits are the same no matter which carrier is selected.

POS plan has the same benefit structure as HMO plan when in-network and PCP services are rendered (same co-pay and out-of-pocket maximums listed in HMO description above).

Unlike the HMO plan, the POS plan allows out-of-network physician visits and hospital visits. Those services are subject to deductibles and 30% co-insurance similar to the PPO plan (described in the PPO section below).

* Out-of-pocket limits are: In-network $1,000 per person and $1,500 per family; Out-of-network $4,000 per person and $8,000 per family.

OR

Preferred Provider Organization (PPO) offered by:

Blue Cross Blue Shield of Arkansas

The PPO plan offers the greatest number of in-network physicians and hospitals but deductibles do apply before any benefits are paid:
$500 individual deductible, $1,000 per family - IN-NETWORK
$750 individual deductible, $1,500 per family - OUT-OF-NETWORK

OUT-OF-POCKET LIMIT after deductible and co-pays are:
In-network, $2,000 per person and $4,000 per family
Out-of-network, $2,500 per person and $5,000 per family

The majority of in-network services are covered at 80% by plan, 20% by member after deductible and co-pays. Majority of out-of-network services are paid at 70% of health plan's maximum allowable, not 70% of billed charges. If provider does not accept maximum allowable, the member is responsible for the difference plus the remaining 30%.

What does each plan cover?

Summary of Most Frequently Used Services Pay Structure

Important Note: The only out-of-network services covered under the pure HMO plans are emergency services and insurance company authorized referrals. The Point of Service (POS) out-of-network reimbursement of the health plan to the provider is 60% of the health plan's approved charges, not of the provider or facility's billed charges. For a more detailed explanation of what each plan covers and what is excluded, please refer to that plan's Summary Plan Description booklet, available from EBD.

	PPO PLAN		HMO & POS PLAN	
PLAN HIGHLIGHT 2003-2004	**IN NETWORK**	**OUT-OF NETWORK**	**HMO & POS IN NETWORK**	**POS OUT-OF NETWORK****
Deductible (First dollar out-of-pocket per plan year)	$500 per person $1,000*** per family	$750 per person $1,500*** per family	$0 $0	$500 per person $1,000*** per family
Coinsurance/ Copayment	20% after deductible	30% after deductible	Per office visit: $20 PCP $25 Specialist	30% after deductible of maximum allowable amount
Out-of-Pocket Limit (after deductible/ copays)	$2,000 per person $4,000*** per family	$2,500 per person $5,000*** per family	$1,000 per person $1,500*** per family	$4,000 per person $8,000*** per family
Physician Services PCP Specialist	20% coinsurance	30% coinsurance	Per office visit: $20 $25	30% coinsurance of maximum allowable amount
Inpatient Physician Services	20% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance
Outpatient Physician Services	20% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance
Outpatient Services	20% coinsurance	30% coinsurance	0% coinsurance after $100 copay for Outpatient Surgical facility	30% coinsurance of maximum allowable amount
Diagnostic Testing (Lab and X-ray)	20% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance

***Satisfied after two (2) family members have met their deductables.

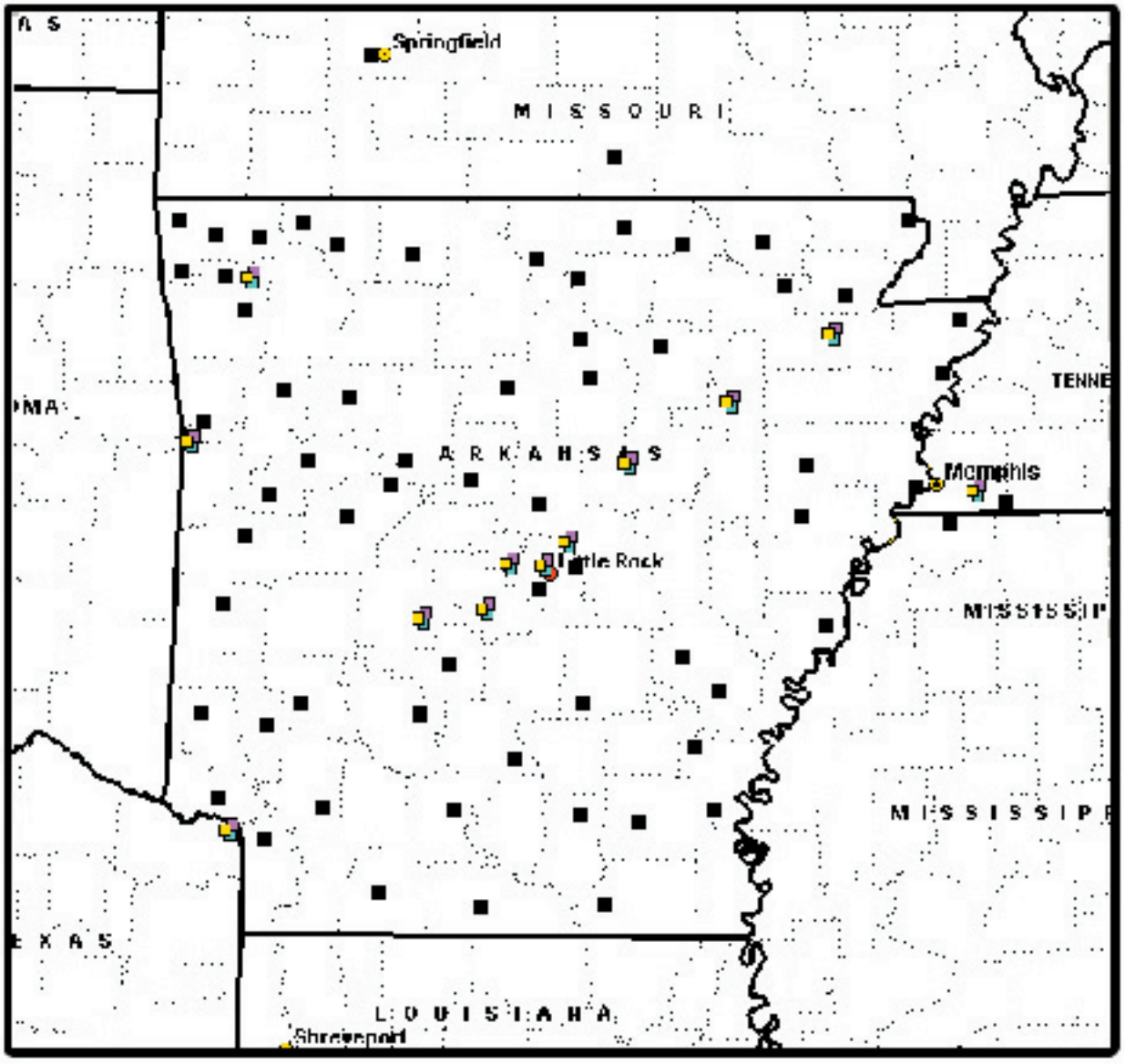
PLAN HIGHLIGHT 2003-2004	PPO PLAN IN NETWORK	PPO PLAN OUT-OF NETWORK	HMO & POS PLAN HMO & POS IN NETWORK	HMO & POS PLAN POS OUT-OF NETWORK**
Ambulance $1,000 annual limit - limit does not apply to medications	20% coinsurance	30% coinsurance	0% coinsurance	30% coinsurance
Inpatient Hospital	20% coinsurance	30% coinsurance	$250 copay plus 10% coinsurance per admission with maximum 3 copays per member per year	30% coinsurance of maximum allowable amount
Preventive Care	Not covered except well-baby and GYN visits 20% coinsurance	Not covered except well-baby and GYN visits 30% coinsurance	Covered $20 PCP $25 Specialist visits	Not covered except well-baby and GYN 30% coinsurance
Mental Health / Substance Care/Physician Inpatient & Outpatient Program	Covered only through CORPHEALTH Behavioral Health Program	Covered only through CORPHEALTH Behavioral Health Program	Covered through CORPHEALTH Behavioral Health Program	Covered through CORPHEALTH Behavioral Health Program
	(See Mental and Behavioral Health section for more details)			
Dental - Limit 2 Preventative Visits per year	Not covered	Not covered	$25 copay	Not covered
Home Health Nursing Visits 120 annual visits	20% coinsurance	30% coinsurance	0% coinsurance	30% coinsurance
Home Infusion IV drugs and Solutions	20% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance
Routine Vision - Exam Limit 1 per member every 24 months	Not covered	Not covered	$25 copay	Not covered

PLAN HIGHLIGHT 2003-2004	PPO PLAN		HMO & POS PLAN	
	IN NETWORK	OUT-OF NETWORK	HMO & POS IN NETWORK	POS OUT-OF NETWORK**
Emergency Care	20% coinsurance	20% coinsurance	$100 copay + 0% coinsurance, copay waived if admitted to same hospital	$100 copay + 0% coinsurance, copay waived if admitted to same hospital
Transplants	Must be approved by plan, then 20% coinsurance	Must be approved by plan, then 30% coinsurance	Must be approved by plan, then $250 per admission copay + 0% coinsurance	Not covered
	*Travel and lodging allowance up to $10,000 lifetime outside service area.			
Durable Medical Equipment Annual Maximum $10,000	20% coinsurance	30% coinsurance	20% coinsurance	30% coinsurance
Durable Medical Equip. Repairs	Must be approved by plan	Must be approved by plan	Must be approved by plan	Must be approved by plan
Physical, Occupational, and Speech Therapy, Chiropractic Services and Cardiac Rehabilitation	20% coinsurance	30% coinsurance	20% coinsurance	30% coinsurance
	(Limited to 60 combined visits per member per year)			
Allergies	20% coinsurance	30% coinsurance	$20 copay PCP $25 copay specialist 0% coinsurance for injections	30% coinsurance

PLAN HIGHLIGHT 2003-2004	PPO PLAN		HMO & POS PLAN	
	IN NETWORK	OUT-OF NETWORK	HMO & POS IN NETWORK	POS OUT-OF NETWORK**
Maternity Benefits	Physician 20% coinsurance	Physician 30% coinsurance	Physician 10% coinsurance, copay for initial office visit	Physician 30% coinsurance
	Hospital 20% coinsurance	Hospital 30% coinsurance	Hospital $250 copay per admission plus 10% coinsurance; subject to the inpatient yearly maximums	Hospital 30% coinsurance
Maximum Benefits	No Maximum	$1,000,000	No Maximum	$1,000,000
Ostomy Supplies	10% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance
Prosthetic	20% coinsurance	30% coinsurance	20% coinsurance	30% coinsurance
	$15,000 annual limit			

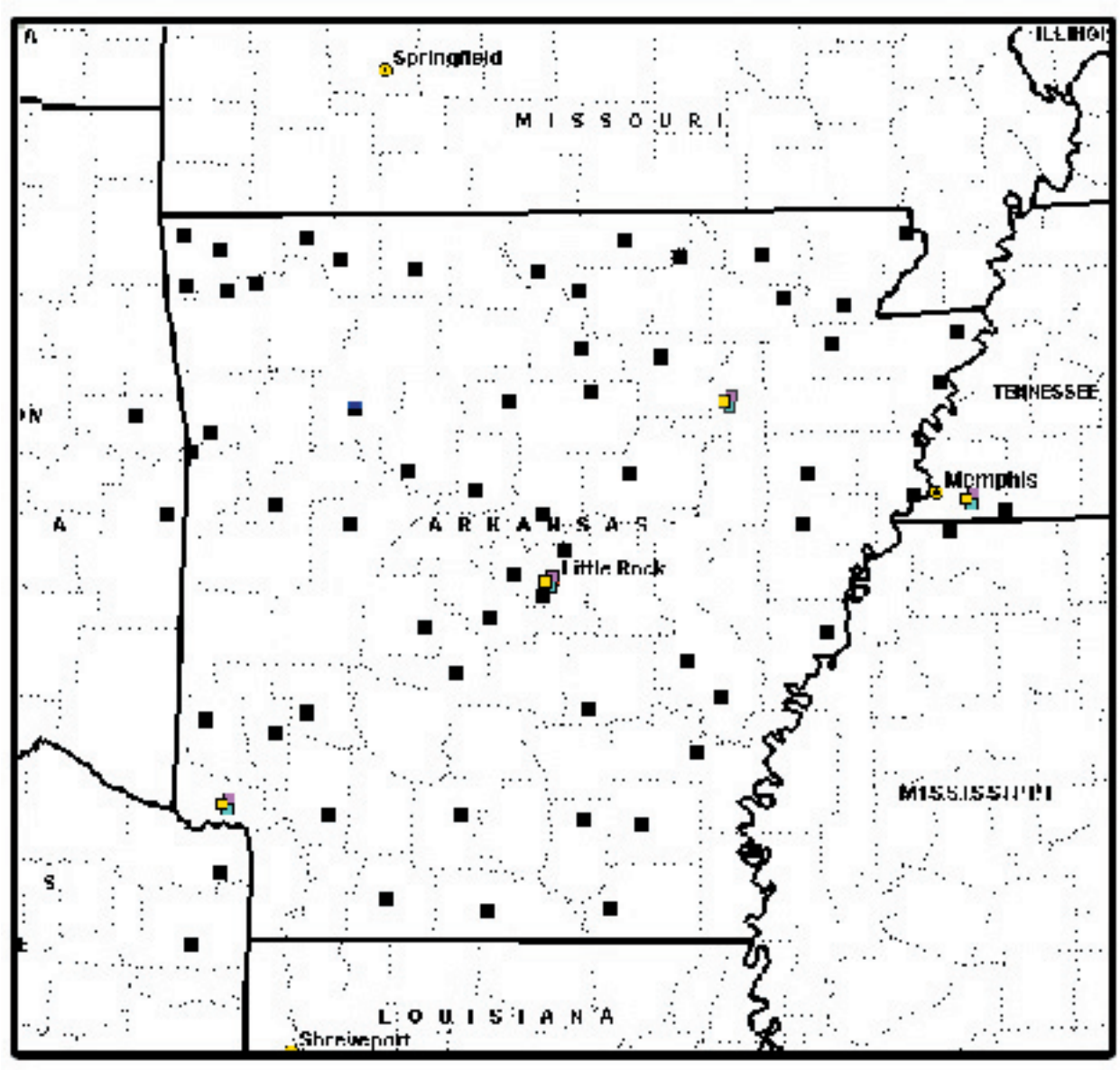
****Out-of-network benefits apply when you do not visit your PCP or follow the plan's referral procedures when visiting a specialist or hospital.**

Blue Cross and Blue Shield PPO
Hospital Network



Please refer to the provider website or call their customer service line for the most current hospital and provider information.

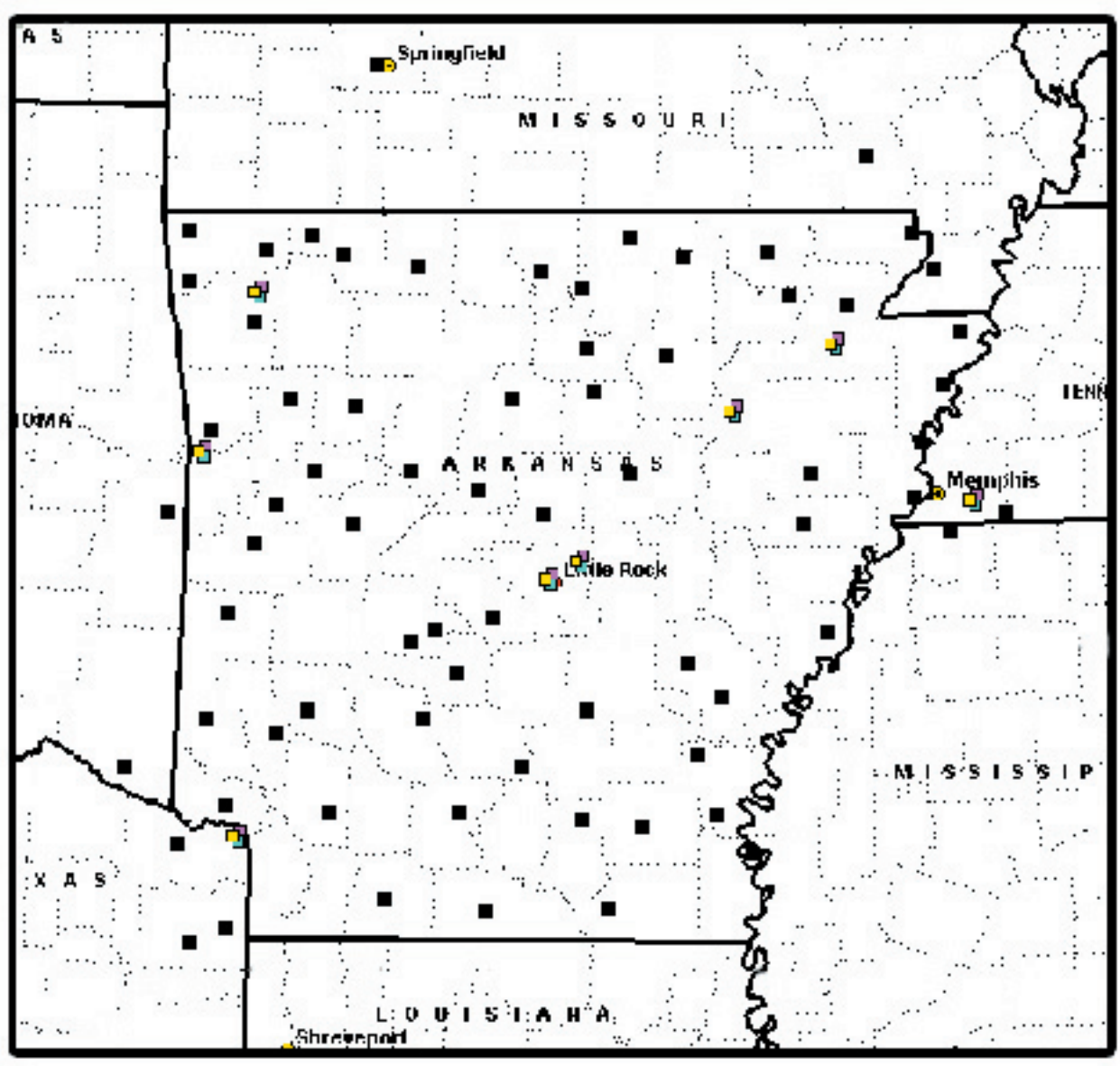
QualChoice HMO & POS
Hospital Network



- hospital
- multiple hospitals in region

Please refer to the provider website or call their customer service line for the most current hospital and provider information.

Health Advantage HMO & POS
Hospital Network



- hospital
- multiple hospitals in region

Please refer to the provider website or call their customer service line for the most current hospital and provider information.

Prescription Drug Program

Your prescription drug program is a stand-alone, self-insured plan, which is included with your group health insurance plan and administered by AdvancePCS. Benefits apply equally to all enrollees regardless of the health care plan you choose. New plan enrollees will automatically receive a prescription drug card that offers important savings on your prescribed medication.

The copays for up to a 34-day supply of medicine, the copayment structure is:

- $10 for generic drugs
- $25 for "formulary" brand-name drugs
- $50 for "non-formulary" brand-name drugs

4th Tier Benefit

In addition to the Generic, Preferred Brand/Formulary, and Non-Formulary categories, Fourth Tier medications are now available at the plan's discounted rate. Examples of Fourth Tier medications are weight loss medication, smoking cessation medication and treatments for hair loss. These types of prescriptions are typically not covered under traditional prescription plans. Our plan will not pay any portion of the prescription, but you will be able to purchase the medication at the same discount the plan pays to pharmacies in our network. You will be responsible for the entire cost of the drug at the discounted rate; you cannot get these prescriptions by paying a copay. Purchases must be made at in-network pharmacy using your AdvancePCS ID card.

Selecting a Pharmacy

There are thousands of participating pharmacies nation-wide and most of your local Arkansas pharmacies will honor your AdvancePCS prescription drug card. For more information about participating pharmacies, including pharmacies in other states, contact AdvancePCS Customer Service at 1-877-456-9586.

Should you find it necessary to fill prescriptions at a non-participating pharmacy, please use the following procedure:

- You must pay the entire cost of the prescription at the point of sale because the pharmacy does not recognize our co-pay structure.
- A paper claim must be completed and submitted to Advance PCS along with receipt from the purchase. That claim form can be obtained at the AdvancePCS website, http://ar.advancerx.com.
- AdvancePCS will reimburse you the difference between the contracted drug cost and the regular copay for that prescription ($10, $25, or $50). NOTE: The contracted price and the retail price are usually different; you will be responsible for that difference. They will also deduct a $1.25 for processing fee.
- You will save money if you use a participating pharmacy whenever possible. A complete list is available at http://ar.advancerx.com or by calling AdvancePCS customer service at 1-877-456-9586.

Pilot Mail Order Pharmacy Program

A mail service prescription benefit is available through AdvancePCS and your local pharmacy. Most long-term medications are available through the mail order provider, AdvanceRX.com, including ostomy supplies, insulin and other diabetic supplies. Medications will be filled with up to a 102 day supply for the cost of 3 standard retail copays. For more information about the mail service benefit or for a complete list of excluded drugs, please call AdvancePCS at 1-877-456-9586 or visit their website, http://ar.advancerx.com.

Ostomy Mail Order Program

Effective October 1, 2003 State and Public School members may choose to receive their ostomy supplies from a national company specializing in ostomy and urological supplies. This company is called EdgePark and they have been in business since 1928. Access to this new service is voluntary, and your benefits will not be affected if you choose to stay with your current supplier. The toll free number for EdgePark is 1-800-321-0591. Please make sure that you identify yourself as a State or Public School employee when you contact EdgePark, as this will enable them to provide prompt and accurate service to you.

Managing The Prescription Drug Program

Your prescription drug program is designed to provide the greatest benefit to the entire group of state and public school employees. This program requires: Prior Authorization (PA) of some medications, Quantity vs. Time (QVT) restrictions that are intended to clarify the usual quantity that constitutes a 34-day supply for particular medications, and Daily Dose Edits in order to eliminate inappropriate utilizations of medications intended for one daily use. The Formulary (Preferred Drug List) is a dynamic entity that will change at least every three (3) months. As new drugs become available they may be added to the formulary and other drugs may be removed from the formulary as generic drugs become available. Drugs may also be removed from the formulary and replaced by other drugs deemed to be more appropriate for our membership. For more information contact AdvancePCS toll-free at 1-877-456-9586.

Generic Drugs

The generic name of a drug is its chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand name drugs must meet the same standards for safety, purity, strength and effectiveness. When you and your doctor authorize generic substitution, it permits the pharmacy to dispense a generic drug. This saves you and your pharmacy program money. Whenever possible, ask your doctor to prescribe generic drugs.

Other Benefits YourPrescription Drug Program Provides

Your prescription drug program offers other benefits for its members such as:

- •Patient Support Program
- •Disease State Management and its participating pharmacists
- •“Specialty Rx” program to supply injectable medication and supplies (call 1-866-295-2779 for more information and to see if you or a family member qualifies).

Diabetic supplies are available without a co-pay at your local pharmacy. Diabetic medicine must be purchased at the same time as the diabetic supplies.

AdvancePCS Web Site

A custom AdvancePCS website is available for our members. The address is www.ar.advancerx.com. The web site offers many features including interactive formulary listing, formulary updates, national pharmacy locator and other member-oriented features. Members can also obtain information on the mail order pharmacy program at this site.

Life Insurance Benefits

Active State employees who are eligible for health benefits sponsored by the State and Public School Employee Life and Health Insurance Board will be automatically enrolled in $10,000 of

Basic Group Term Life and Accidental Death and Dismemberment (AD&D) coverage with USAble Life.

In addition to the Basic Group Term Life and AD&D, you are eligible to participate in USAble's Supplemental Life and AD&D program. This program allows you to obtain up to two (2) times your annual salary in Supplemental Life benefits. Also you may elect up to $20,000 of coverage on each of your eligible dependents.

To determine the amount of Supplemental Life for which you qualify, or for more details regarding your Group Term Life insurance, contact your state agency insurance representative.

ENROLLMENT

New employees will have thirty (30) days from their hire date to enroll in the Supplemental Life program without evidence of insurability. If you are currently insured by the State Employee group health plan, but have not elected the Supplemental Life, you may apply by providing evidence of insurability. Please contact your state agency insurance representative to obtain a Supplemental Life application.

Mental and Behavioral Health Benefits

CORPHEALTH coordinates ALL behavioral health care for Arkansas State enrollees. Your benefit program and network of mental healthcare providers are completely separate from your medical, no matter which medical plan you select. Mental Health and Substance Abuse and an Employee Assistance Program (EAP), named the StarEAP, are included in the Behavioral Health Care Benefit.

You must access your behavioral health care benefit by calling the Arkansas Helpline and a CORPHEALTH network provider must deliver your care.

All services require pre-authorization by CORPHEALTH

The benefits include the StarEAP and a completely redesigned mental health and chemical dependency benefit. You do not have to obtain a referral from your Primary Care Physician to seek help from the StarEAP Employee Assistance Program or to access your mental health or substance abuse benefits. All contact with Corphealth is strictly confidential.

Access is easy. Simply call the Arkansas Help Line toll-free at 1-866-378-1645 24 hours a day, 365 days a year.

- You'll have immediate access to a professional to help you assess your needs, sort through your options, and find effective resources.
- Telephonic and/or face-to-face sessions with one of the EAP affiliate counselors.
- Pre-certification for mental health and substance abuse treatment.
- Individualized referrals to resources in your community.

The StarEAP program provides you with short-term assessment and counseling with no copay for you or your covered dependents. The StarEAP provides immediate access to a clinical assessment and outpatient EAP treatment of up to eight (8) sessions, and/or referral to a behavioral health (mental health or chemical dependency) specialist that is covered under the plan at the benefit schedule summarized below:

The StarEAP benefits include a complete range of services such as:

Emotional Well-Being

- •Personal relationships
- •Marriage and family issues
- •Divorce and separation
- •Coping with violence
- •Grief and loss

Addiction and Recovery Assessments & Referrals to Specialists

- •Alcohol and drugs
- •Gambling
- •Other addictions
- •Support groups
- •Eating disorders

Parenting

- •Single parenting and blended families
- •Discipline, setting limits and safety
- •Child development

Work

- •Work and personnel issues
- •Adjusting to change in the workplace
- •Stress management

Financial

- •Referral
- •Budgeting
- •Managing credit and collections problems

Legal

- •Referrral to community resources

Key Things to Remember:

- •Always access the benefit by first calling the Arkansas Help Line, 1-866-378-1645.
- •**<u>All services require pre-authorization.</u>**
- •Information about providers and benefits is available at www.corphealth.com. There will be no benefit for non-CORPHEALTH network providers where the care is not directed by CORPHEALTH, Inc. or is not an emergency.
- •Always obtain a referral authorization from your CORPHEALTH case manager by calling the Arkansas Help Line at 1-866-378-1645

Benefit Description	In-Network	Out-of-Network
I. Employee Assistance Program (EAP) Star EAP Telephonic Consultation and Face-to-Face Short Term/Brief Issue Resolution Counseling	Up to eight (8) EAP sessions per episode with no copayment. Must call Arkansas Help Line at 1-866-378-1645.	Not covered
II. Initial Behavioral Health Benefit	Must call Arkansas Help Line at 1-866-378-1645.	Not covered
Deductible:	$0 Individual $0 Family	$0 Individual $0 Family
Copayment for Traditional Out-Patient Services	$25 copay/ office visit	$25 copay + 25% coinsurance
Out-of-Pocket Maximum (After copays and deductibles)	$1,000 Individual $1,500 Family	$1,250 Individual $1,875 Family
Out-Patient Services (Partial hospital / day treatment)	$0 Copay + 25% coinsurance	$0 copay first visits 25% coinsurance
Out-Patient Services (Intensive Outpatient)	$0 Copay	$0 copay 25% coinsurance
Residential Treatment	10% Coinsurance	35% coinsurance
In-Patient Services	$250 Copay 10% coinsurance per admission	$300 copay + 35% coinsurance/admit
Anasthesia services for Electro Convulsant Therapy	Requires pre-authorization. Only covered at a Bridgeway facility	Not covered
Maximum Lifetime Benefit	$1,000,000	$25,000

Out of Network Coinsurance will pay the indicated percentage of the maximum allowable.

All mental health or substance abuse services must be preauthorized by CORPHEALTH prior to receiving care. All mental health and substance abuse claims for care rendered must be submitted to:

Claims Department
CORPHEALTH, Inc.
1701 Centerview Dr., Suite 101 Little Rock, AR 72211

Visit the CORPHEALTH web site at www.corphealth.com / Members. State of Arkansas Plan Members can access custom plan information by logging in with the user name “STAREAP” and password, “STAREAP” from this page.

Inpatient

For all enrollees receiving inpatient care in an acute, partial hospitalization, residential treatment or intensive outpatient program level of care, the current Health Plan is responsible for managing the care

and processing the claim until the enrollee has been discharged from that level of care. You must call CORPHEALTH at 1-866-378-1645 to pre-certify any care that may be necessary after you are discharged from any of the above-mentioned treatment levels. Please contact the Arkansas Help Line toll-free at 1-866-378-1645 (7 days a week, 24 hours a day) if you have additional questions.

Frequently Asked Questions about Corphealth and StarEAP

What is the difference between the StarEAP and Managed Care benefit?

StarEAP is designed to help you resolve short term problems related to work, relationships, parenting, finances, state, elder care, etc. And does not require a referral from your primary care physician.

Managed Care is designed to address medically diagnosed mental health problems which require treatment for a period of 3 months or more. Treatment can include medication, psychiatric/psychological evaluation, individual, group or family therapy. You receive unlimited sessions, as long as they are medically necessary. There is a co-pay.

Do I have a choice of providers?

Yes. There are licensed clinicians (master's level, doctorate level and physicians) throughout the state and you can go to any provider in the Corphealth network, statewide. You can call Corphealth directly or go to their website www.corphealth.com for a current list of providers.

Note: If you require medical care for a mental health problem you must use a hospital in your medical plan's network.

Is my family eligible for mental health benefits?

State employees are eligible for StarEAP benefits if enrolled. Family members can participate in couple or family sessions with the employee. Enrollees in the health plan and their enrolled dependents are eligible for managed care benefits.

Will my employer know if I use StarEAP?

Your use of the EAP benefit is strictly confidential. In order for information about your participation in the EAP to be released to anyone, you must sign an authorization to release information. Employers can refer you to the EAP if they feel it can be of help to you, if they are concerned about your work performance or if you have a drug free work policy and test positive for a drug screen. Employer referrals to the EAP may require your participation in the EAP, but again, **you must sign a release in order for your information to be shared with your employer.**

How much will this cost me?

State Employees - Actives
January 1, 2004 Self-Insured Premium Rates

	Total Monthly Health Premium	Less State Contribution	Total Monthly Health Employee Cost	24thly Health Cost to Employee
Employee Only				
BCBS PPO	$405.62	($227.98)	$177.64	$88.82
QualChoice POS	$298.28	($227.98)	$70.30	$35.15
Health Advantage POS	$295.98	($227.98)	$68.00	$34.00
Health Advantage HMO	$289.20	($227.98)	$61.22	$30.61
QualChoice HMO	$287.26	($227.98)	$59.28	$29.64
Employee & Spouse				
BCBS PPO	$971.19	($449.97)	$521.22	$260.61
QualChoice POS	$713.59	($449.97)	$263.62	$131.81
Health Advantage POS	$708.09	($449.97)	$258.12	$129.06
Health Advantage HMO	$691.81	($449.97)	$241.84	$120.92
QualChoice HMO	$687.15	($449.97)	$237.18	$118.59
Employee & Child(ren)				
BCBS PPO	$608.97	($308.01)	$300.96	$150.48
QualChoice POS	$447.97	($308.01)	$139.96	$69.98
Health Advantage POS	$444.53	($308.01)	$136.52	$68.26
Health Advantage HMO	$434.35	($308.01)	$126.34	$63.17
QualChoice HMO	$431.45	($308.01)	$123.44	$61.72
Employee & Family				
BCBS PPO	$1,078.57	($493.13)	$585.44	$292.72
QualChoice POS	$794.13	($493.13)	$301.00	$150.50
Health Advantage POS	$788.07	($493.13)	$294.94	$147.47
Health Advantage HMO	$770.09	($493.13)	$276.96	$138.48
QualChoice HMO	$764.95	($493.13)	$271.82	$135.91

State Employees- COBRA*
January 1, 2004 Self Insured Premium Rates

	Total Monthly Premium	COBRA Admin Fee	Total Monthly Premium
Employee Only			
BCBS PPO	$405.62	$8.11	$413.73
QualChoice POS	$298.28	$5.97	$304.25
Health Advantage POS	$295.98	$5.92	$301.90
Health Advantage HMO	$289.20	$5.78	$294.98
QualChoice HMO	$287.26	$5.75	$293.01
Employee & Spouse			
BCBS PPO	$971.19	$19.42	$990.61
QualChoice POS	$713.59	$14.27	$727.86
Health Advantage POS	$708.09	$14.16	$722.25
Health Advantage HMO	$691.81	$13.84	$705.65
QualChoice HMO	$687.15	$13.74	$700.89
Employee & Child(ren)			
BCBS PPO	$608.97	$12.18	$621.15
QualChoice POS	$447.97	$8.96	$456.93
Health Advantage POS	$444.53	$8.89	$453.42
Health Advantage HMO	$434.35	$8.69	$443.04
QualChoice HMO	$431.45	$8.63	$440.08
Employee & Family			
BCBS PPO	$1,078.57	$21.57	$1,100.14
QualChoice POS	$794.13	$15.88	$810.01
Health Advantage POS	$788.07	$15.76	$803.83
Health Advantage HMO	$770.09	$15.40	$785.49
QualChoice HMO	$764.95	$15.30	$780.25

***Note: COBRA will be administered by EBD effective January 1, 2004.**

State Retirees Rate Information

Medicare Part A and Part B

Coordination of benefits will be applied to all plans. This means that coverage under government programs, including Medicare, required or provided by any statute unless coordination of benefits with any such program is forbidden by law. ***Subscribers and Dependents who are eligible for Medicare must have both Part A and B***. If a member eligible for Medicare does not have Medicare Part B, the plan will pay as though the member does have Medicare Part B and the member will have full financial responsibility for claims incurred.

NOTE: The general Medicare Open Enrollment period is from January through March each year for a July 1st effective date. Retirees without Medicare Part B should contact the Social Security Administration about obtaining Part B coverage at 1-800-772-1213. Medicare Part B premiums are monthly and may increase up to 10% for each 12 month period that you could have had Part B but did not sign up for it (there are some special exceptions).

State Retiress -Medicare Primary
January 1, 2004 Self-Insured Premium Rates

	Total Monthly Premium	State Contribution	Total Monthly Employee Cost
Retiree Medicare Only			
BCBS PPO	$228.77	($60.52)	$168.25
QualChoice POS	$178.56	($60.52)	$118.04
Health Advantage POS	$174.64	($60.52)	$114.12
Health Advantage HMO	$171.68	($60.52)	$111.16
QualChoice HMO	$171.67	($60.52)	$111.15
Retiree Medicare & Spouse			
BCBS PPO	$842.51	($210.99)	$631.52
QualChoice POS	$603.97	($210.99)	$392.98
Health Advantage POS	$585.36	($210.99)	$374.37
Health Advantage HMO	$571.28	($210.99)	$360.29
QualChoice HMO	$571.24	($210.99)	$360.25
Retiree Medicare & Child(ren)			
BCBS PPO	$360.92	($124.23)	$236.69
QualChoice POS	$273.05	($124.23)	$148.82
Health Advantage POS	$266.20	($124.23)	$141.97
Health Advantage HMO	$261.01	($124.23)	$136.78
QualChoice HMO	$261.00	($124.23)	$136.77
Retiree Medicare & Spouse & Child(ren)			
BCBS PPO	$982.57	($239.76)	$742.81
QualChoice POS	$706.37	($239.76)	$466.61
Health Advantage POS	$684.83	($239.76)	$445.07
Health Advantage HMO	$668.52	($239.76)	$428.76
QualChoice HMO	$668.48	($239.76)	$428.72
Retiree Medicare & Spouse Medicare			
BCBS PPO	$457.31	($117.18)	$340.13
QualChoice POS	$356.90	($117.18)	$239.72
Health Advantage POS	$349.06	($117.18)	$231.88
Health Advantage HMO	$343.13	($117.18)	$225.95
QualChoice HMO	$343.12	($117.18)	$225.94

State Retirees - Not Medicare Primary
January 1, 2004 Self-Insured Premium Rates

	Total Monthly Premium	State Contribution	Total Monthly Retiree Cost
Employee Only			
BCBS PPO	$613.96	($194.12)	$419.84
QualChoice POS	$425.63	($194.12)	$231.51
Health Advantage POS	$410.94	($194.12)	$216.82
Health Advantage HMO	$399.82	($194.12)	$205.70
QualChoice HMO	$399.79	($194.12)	$205.67
Employee & Spouse			
BCBS PPO	$1,227.70	($342.16)	$885.54
QualChoice POS	$851.04	($342.16)	$508.88
Health Advantage POS	$821.66	($342.16)	$479.50
Health Advantage HMO	$799.42	($342.16)	$457.26
QualChoice HMO	$799.37	($342.16)	$457.21
Employee & Child(ren)			
BCBS PPO	$956.27	($295.53)	$660.74
QualChoice POS	$654.93	($295.53)	$359.40
Health Advantage POS	$631.42	($295.53)	$335.89
Health Advantage HMO	$613.63	($295.53)	$318.10
QualChoice HMO	$613.58	($295.53)	$318.05
Employee & Family			
BCBS PPO	$1,787.84	($531.76)	$1,256.08
QualChoice POS	$1,222.90	($531.76)	$691.14
Health Advantage POS	$1,178.83	($531.76)	$647.07
Health Advantage HMO	$1,145.48	($531.76)	$613.72
QualChoice HMO	$1,145.39	($531.76)	$613.63
Employee & Medicare Spouse			
BCBS PPO	$842.51	($210.99)	$631.52
QualChoice POS	$603.97	($210.99)	$392.98
Health Advantage POS	$585.36	($210.99)	$374.37
Health Advantage HMO	$571.28	($210.99)	$360.29
QualChoice HMO	$571.24	($210.99)	$360.25
Employee & Medicare Spouse & Child(ren)			
BCBS PPO	$982.57	($239.76)	$742.81
QualChoice POS	$706.37	($239.76)	$466.61
Health Advantage POS	$684.83	($239.76)	$445.07
Health Advantage HMO	$668.52	($239.76)	$428.76
QualChoice HMO	$668.48	($239.76)	$428.72

ENROLLMENT FORM INSTRUCTIONS

The State Employees Enrollment Form (#6000-F-1A) is used by new employees, employees wanting to change health plans, or for mid-year enrollments allowed under Cafeteria plan rules.

These instructions will assist you in completing the State Employees Enrollment Form enclosed in this booklet. When the form is completed, please submit to your agency office for processing. The instructions are organized to correspond with the numbered sections of the form.

PLEASE NOTE: Incomplete, illegible or otherwise unclear forms will be returned to you for correction and could possibly cause a delay in processing your enrollment.

1. **Employee Information:** Please provide the demographic information requested.
   - If you do not wish to enroll in the health benefits, please complete section one (except Primary Care Physician information) and check the box in the heading beside the words "I decline coverage for myself."
   - If you have an email address, we would like to have it in order to communicate benefit information to you electronically.
   - Primary Care Physician (PCP) information is only required for members of the HMO or POS plans. Do not list a PCP if you are enrolling in the PPO plan. (The health plans no longer require a separate OB/GYN selection).
2. **Dependent Coverage Information:** Please provide complete information for each dependent you wish to enroll on your health plan.
   - If you are married and/or have other dependents but do not wish to enroll them on this health plan, please indicate by checking box beside the words, "I decline coverage for my dependents" in the header of section two.
   - Notice that the first dependent section is for SPOUSE information and subsequent blanks are for other dependents.
   - If dependent(s) is/are age 19 or over, they must be a full-time student to continue on the insurance. Please indicate whether they are a full time student and provide documentation to the Employee Benefits Division.
   - If applicable, please submit court orders for guardianship, court ordered insurance coverage or adoption papers for dependents enrolled under your plan.
   - You may write over the gray words indicating where FIRST NAME, LAST NAME, (Middle Initial) and SEX are to be written.
   - If you have more dependents than space allows, please attach an additional sheet containing the required information.
3. **I Wish To Enroll In The Following Plan:** Indicate the plan in which you want to enroll and at what level of coverage.
   - Please check only ONE box in the HMO, POS or PPO section to indicate your plan selection. You and your dependents must be on the same plan.
   - But also check the level of coverage you desire (Employee Only, Employee & Spouse, etc.) on the last horizontal box of section three.
4. **Other Medical Insurance:** In order to aid coordination of benefits with other health plans you carry, please provide complete information in this section.
5. **To Be Completed By Agency:** Please return this completed form to your state agency State Agecny Representative for processing.
6. **Please Read Before Signing:** Read entire section then sign and date the form on the lines provided. We suggest you make a copy of this enrollment form for your records. Additional copies of this form may be printed from our website, www.accessarkansas.org/dfa/ebd, by clicking on the Benefits Library link.

STATE OF ARKANSAS
Department of Finance
and Administration

EBD
Employee Benefits Division
Post Office Box 15610
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-2366 http://www.state.ar.us/dfa/ebd

State Employees
Enrollment Form

1. Employee Information: (please print)				❒ I decline coverage for myself
Last Name	First Name	MI	Sex	☐ Married ☐ Single
Home Address	City	State	Zip Code	
Social Security #:	Date of Birth:	Home #:	Work #:	
If you would like benefit information sent to you by email, please print your email address:				
†Primary Care Physician:	PCP #	Current patient?		

†Primary Care Physician lines are applicable for HMO and POS enrollees only, not PPO.

2. Dependent Coverage Information:			❒ I decline coverage for my dependents
SPOUSE			
FIRST NAME	LAST NAME	MI	SEX
Social Security #:	Date of Birth:		
†Primary Care Physician:	PCP #	Current patient?	
DEP 1*			
FIRST NAME	LAST NAME	MI	SEX
Social Security #:	Date of Birth:	Full time student?**	
†Primary Care Physician:	PCP #	Current patient?	
DEP 2*			
FIRST NAME	LAST NAME	MI	SEX
Social Security #:	Date of Birth:	Full time student?**	
†Primary Care Physician:	PCP #	Current patient?	
DEP 3*			
FIRST NAME	LAST NAME	MI	SEX
Social Security #:	Date of Birth:	Full time student?**	
†Primary Care Physician:	PCP #	Current patient?	
DEP 4*			
FIRST NAME	LAST NAME	MI	SEX
Social Security #	Date of Birth	Full time student?**	
†Primary Care Physician:	PCP #	Current patient?	

* Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply
**For dependents 19 and over only

3. I Wish To Enroll In The Following Plan:		
H.M.O	P.O.S.	P.P.O
☐ Health Advantage ☐ QualChoice/QCA	☐ Health Advantage ☐ QualChoice/QCA	☐ Arkansas Blue Cross and Blue Shield
☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Family		

4. Other Medical Insurance:

1) Will you or any of your family members be continuing any other health insurance? ❒Yes ❒No
2) If Yes, what type of coverage? ❒ Medical ❒ Medicare, HIC # _____
If Medicare: Part A Effective Date / / or Part B Eff Date / /
If Medicare: Reason for Coverage: ❒ Over age 65 ❒ Disabled ❒ Kidney Disease
Please make sure EBD and your carrier has a copy of your Medicare card.
If you answered Yes to the question above, complete below: (Use additional paper if necessary)

Covered Person's Name	Coverage Type (single/family)	Effective Date	Policy Holder's Employer

Name/Address/Phone/Policy # of Health Ins Co.:

5. To Be Completed By Agency:

Agency #:	Name of Agency	
Employee #:	Hire Date:	Effective Date of Coverage:
If employee is transferring from another agency, please provide name:		

Insurance Representative Signature: _____

Print Name: _____

6. Please Read Before Signing:

I understand and agree that: (1) The information provided on this application is accurate and complete. (2) Any omissions or incorrect statements made by myself or anyone on this application may invalidate my and/or my dependents' coverage. (3) Coverage will become effective only on the date specified by the Insurer after the application has been approved by the Insurer and after the first full premium has been paid. (4) My signature authorizes Coordination of Benefits under this coverage with other insurance I have that is subject to coordination. (5) I hereby authorize deductions from my earnings of any required insurance contribution. (6) By signing this enrollment form, I hereby certify that all the information provided is true and correct.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application, I authorize any health care professional or entity to give the health plan/insurer and the employer or any of their designees, any and all records or information pertaining to medical history or services rendered to the health plan/insurer, for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purpose, including evaluation of an application or a claim. I also authorize on behalf of health plan/insurer, the use of a Social Security Number for purpose of identification. A photocopy of this authorization will be as valid as the original.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I understand that if I refuse to apply now and I apply for coverage at a later date, my request may be deferred until open enrollment.

Employee's Signature: _____ **Date:** _____

RETIREE ENROLLMENT FORM INSTRUCTIONS

The State Retiree Enrollment Form (#6000–f-1c) has been designed especially for use by Retired State Employees. In the past, retirees have used the active employee enrollment form and tolerated sections of it that did not apply to them. We hope you find this new form to be useful and better suited to your needs.

NOTE: If you do not wish to change any aspect of your health coverage, you do not need to complete anything. Your insurance will stay the same and the new rates will be effective January 1, 2004. Please see rate charts in this booklet.

Please use the State Retirees Enrollment Form (#6000-f-1c) if you wish to move from one health plan or health carrier to another. If you want to drop dependents from your plan or add them because of a family status change, but still remain on the same health plan, please use the Change Form (#6000-f-2) also included in this booklet.

Enrollment and Change forms should be postmarked and sent to Employee Benefits Division by October 31, 2003. New enrollments and changes will be effective January 1, 2004.

The following instructions will assist you in completing the State Retirees Enrollment Form enclosed in this booklet. When the form is completed, please submit to the Employee Benefits Division (EBD) for processing. Our mailing address is on the top right corner of the form. The instructions are organized to correspond with the numbered sections of the form.

PLEASE NOTE: Incomplete, illegible or otherwise unclear forms will be returned to you for correction and could possibly cause a delay in processing your enrollment.

1. **Retiree Information:** Please provide the demographic information requested.
   - *If you do not wish to enroll in the health benefits, please complete section one (except Primary Care Physician information) and check the box in the heading beside the words "I decline coverage for myself."*
   - If you have an email address, we would like to have it in order to communicate benefit information to you electronically.
   - Primary Care Physician (PCP) information is only required for members of the HMO or POS plans. Do not list a PCP if you are enrolling in the PPO plan.
2. **Dependent Coverage Information:** Please provide complete information for each dependent you wish to enroll on your health plan.
   - *If you are married and/or have other dependents but do not wish to enroll them on this health plan, please indicate by checking box beside the words, "I decline coverage for my dependents" in the header of section two and skip to the signature line on the back of the form.*
   - Notice that the first dependent section is for SPOUSE information and subsequent blanks are for other dependents.
   - If dependent(s) is/are age 19 or over, they must be a full-time student to continue on the insurance. Please indicate whether they are a full time student and provide documentation to the Employee Benefits Division.
   - If applicable, please submit court orders for guardianship, court ordered insurance coverage or adoption papers for dependents enrolled under your plan.

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STATE OF ARKANSAS
Department of Finance
and Administration

EBD
Employee Benefits Division
Post Office Box 15610
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-2366 http://www.state.ar.us/dfa/ebd

State Retirees Enrollment Form

R

1. Retiree Information: (please print) ❒ I decline coverage for myself

Last Name	First Name	MI	Sex	❒ Married ❒ Single
Home Address	City	State	Zip Code	
Social Security #:	Date of Birth:	Home #:	Second #:	
If you would like benefit information sent to you by email, please print your email address:				
†Primary Care Physician:	PCP #	Current patient?		

†Primary Care Physican lines are applicable for HMO and POS enrollees only, not PPO.

2. Dependent Coverage Information: ❒ I decline coverage for my dependents

SPOUSE	FIRST NAME	LAST NAME	MI	SEX
	Social Security #:	Date of Birth:		
	†Primary Care Physician:	PCP #:	Current patient?	
DEP 1*	FIRST NAME	LAST NAME	MI	SEX
	Social Security #:	Date of Birth:	Full time student?**	
	†Primary Care Physician:	PCP #	Current patient?	
DEP 2*	FIRST NAME	LAST NAME	MI	SEX
	Social Security #:	Date of Birth:	Full time student?**	
	†Primary Care Physician:	PCP #	Current patient?	
DEP 3*	FIRST NAME	LAST NAME	MI	SEX
	Social Security #:	Date of Birth:	Full time student?**	
	†Primary Care Physician:	PCP #	Current patient?	

* Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply
**For dependents 19 and over only

3. I Wish To Enroll In The Following Plan:

H.M.O	P.O.S.	P.P.O
❒ Health Advantage ❒ QualChoice/QCA	❒ Health Advantage ❒ QualChoice/QCA	❒ Arkansas Blue Cross and Blue Shield

❒ Employee Only ❒ Employee & Spouse ❒ Employee & Children ❒ Family

Rev. 7/1/03 6000-f-1c

4. Other Medical Insurance:

1) Will you or any of your family members be continuing any other health insurance? ❒Yes ❒No
2) If Yes, what type of coverage?(Self): ❒ Medical ❒ Medicare (Other): ❒ Medical ❒ Medicare
If Medicare (Self): HIC #: _____ Effective Date- Part A: _____ Part B: _____
(Other): HIC #: _____ Effective Date- Part A: _____ Part B: _____
If Medicare, reason for coverage: ❒ Over age 65 ❒ Disabled ❒ Kidney Disease
Please make sure EBD and your carrier has a copy of your Medicare card.
If you answered Yes to the question above, complete below: (Use additional paper if necessary)

Covered Person's Name	Coverage Type (single or family)	Effective Date	Policy Holder's Employer

Name/Address/Phone/Policy # of Health Ins Co.:

5. Please Read Before Signing:

I understand and agree that: (1) The information provided on this application is accurate and complete. (2) Any omissions or incorrect statements made by myself or anyone on this application may invalidate my and/or my dependents' coverage. (3) Coverage will become effective only on the date specified by the Insurer after the application has been approved by the Insurer and after the first full premium has been paid. (4) My signature authorizes Coordination of Benefits under this coverage with other insurance I have that is subject to coordination. (5) I hereby authorize deductions from my retirement earnings of any required insurance contribution. (6) By signing this enrollment form, I hereby certify that all the information provided is true and correct.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application, I authorize any health care professional or entity to give the health plan/insurer and the employer or any of their designees, any and all records or information pertaining to medical history or services rendered to the health plan/insurer, for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purpose, including evaluation of an application or a claim. I also authorize on behalf of the health plan/insurer, the use of a Social Security Number for purpose of identification. A photocopy of this authorization will be as valid as the original.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I understand that if I refuse to apply for coverage at retirement, that I may not be eligible for coverage at a later date.

Retiree's Signature: _____ **Date:** _____

WEB ENROLLMENT OPTION

The Employee Benefits Division is proud to announce that electronic enrollment is now available to our State Retirees! Our new system is called "ARBenefits." You may access the ARBenefits link from our Arkansas Employee Benefits Division website (www.accessarkansas.org/dfa/ebd). The following page contains a form to request sign-on and password if you are interested in using this feature.

Web enrollment for State Retirees will be available during the open enrollment period of October 1 -31, 2003. Submission of online forms must be completed by midnight CST, October 31, 2003.

You must print, sign and mail the forms to EBD.

The web enrollment form will be the same as the paper form enclosed in this booklet. It may be helpful for you to complete the paper form and use it as a guide when completing the form online.

This is an OPTION – not a requirement. You may choose to complete and return the traditional paper enrollment form enclosed in this booklet.

STATE OF ARKANSAS
Department of Finance
and Administration

EBD
Employee Benefits Division
Post Office Box 15610
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-1168 http://www.state.ar.us/dfa/ebd

Retiree Computer Access Confidentiality Agreement

Official request for a sign-on code and password to access EBD online forms.

Print Name: _____ SSN: _____-___-_____

I, the undersigned, acknowledge that receipt of my sign-on code(s) to the EBD Network and Systems and understand the following:

- My sign on code and password(s) will be used as personal identification for purposes of data access in the same manner as my signature is used for identification.
- I will not disclose my sign-on password code(s) to anyone unless there is a necessity to do so.
- * I will never attempt to learn another person's sign-on password .
- * I will not attempt to access information on the EBD network except to meet my needs. .
- * I will not divulge any knowledge that I gain, with regards to EBD computer or network security.
- If I discover any breach of confidentiality, or unauthorized access I will notify the EBD Privacy and Security officer immediately.

Monitoring Access to Confidential Data

* Department of Finance and Administration departments, which support computer information systems will monitor use of the systems and will report access or confidentiality violations immediately to the Operations Manager, Privacy Security Officer, and to the Executive Director of EBD.

I, the undersigned, further understand and agree that the consequences of a violation of the above statements may result in revocation of my continued access to web based enrollment or other web based applications.

Signature: _____ Date: _____

Please return original to EBD at the address above. Your sign on code, password and instructions will be sent to you soon after receipt of this application.

EBD USE ONLY:

Privacy/Security Officer Signature: _____ Date: _____

☐ SENT - Sign on code _____ Password _____

CHANGE FORM INSTRUCTIONS

The ***Change Form*** **(#6000-f-2**) is used to make a change OTHER THAN changing to a different health plan or different carrier. The Change Form should be completed and submitted to your State Agency Insurance Representative for the following reasons:

- to add or delete dependents from health insurance plan during open enrollment or during the plan year according to Cafeteria plan (IRS Section 125) rules which may allow a change in coverage status, i.e. Employee Only, Employee & Spouse, etc.
- to indicate the reason for making a change such as birth of a child, marriage, etc.
- to change retiree's / employee's mailing address or name

If the intent is to change health plans or health carriers, please use the *State Enrollment Form* (#6000-f-2).

PLEASE NOTE: Incomplete, illegible or otherwise unclear forms will be returned for correction and could possibly cause a delay in processing the change.

The following instructions outline the process for completing the Change Form on the following page. (This is the same form currently used by Active State Employees, so disregard any reference to State Agency Insurance Representative.) The instructions are organized to correspond with the numbered sections of the form. Only use the Change Form for the purpose of making the changes indicated by the bullet points above.

1. **Employee Information (Retiree Information)**: Please provide the demographic information requested.
   - If not previously provided, please print your email address if you would like benefit updates and information mailed to you as the need arises.
   - Primary Care Physician (PCP) information is only required for members of the HMO or POS plans. Do not list a PCP if you are enrolled in the PPO plan.

2. **Change in Dependent Status:** If you want to add or delete a dependent from the plan, please provide complete information for each dependent.
   - Write over the gray words indicating where FIRST NAME, LAST NAME, MI (Middle Initial) and SEX are to be written.
   - Please provide Social Security Number of the dependent, date of birth and whether the intent is to ADD or DELETE them from the policy.
   - If dependents are being DELETED from the policy, it is not necessary to indicate Primary Care Physician (PCP), PCP# or Student Status. If you are ADDING a dependent, please complete all of those blanks.
   - If dependent(s) is/are age 19 or over, they must be a full-time student at an accredited institution to continue on the insurance. Please indicate whether they are a full time student and provide documentation to your chosen health insurance carrier. We have created a *Student Status Form* (#6000-f-3) for this purpose available on our website, www.accessarkansas.org/dfa/ebd by clicking on the Benefits Library link.
   - If applicable, please submit court orders for guardianship, court ordered insurance coverage or adoption papers for dependents being adding to the policy.
   - Please attach additional sheets if it is necessary to add more dependents than space allows. You may either attach another copy of the same form or otherwise provide the information requested.

2. **Change in Coverage:** Please complete this section if you want to make any of the changes indicated in the list in that section. NOTE: We would appreciate you indicating which health plan you are enrolled in currently even if you are not making a change indicated by the boxes. Remember, this form is not to be used to CHANGE PLANS or CARRIERS. Taking the time to indicate your current plan will provide us a double check of your plan enrollment.

3. **To be completed by Agency or School District**: Employees please do not complete this section. Your Agency Representative will complete this section and forward to the Employee Benefits Division (EBD) for processing. **Please do not send this form directly to EBD.**

4. **Employee Signature (Retiree Signature)**: Sign and date the form on the lines provided. We suggest you make a copy of this form for your records. Additional copies may be printed from our website, www.accessarkansas.org/dfa/ebd by clicking on the Benefits Library link.

Send the completed Change form to:

EBD
PO Box 15610
Little Rock, AR 72231-5610

by October 31, 2003. Changes will go into effect on January 1, 2004.

STATE OF ARKANSAS
Department of Finance
and Administration

EBD
Employee Benefits Division
Post Office Box 15610
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-2366 www.state.ar.us/dfa/ebd

Change Form
Status, Name and Address

1. Employee Information: (please print)				
Last Name	First Name		MI	☐ Married ☐ Single
Home Address	City	State	Zip Code	
SSN#	Date of Birth:	Home #:	Work #:	
If you would like benefit information sent to you by email, please print your email address:				
Primary Care Physician:	PCP #	Current patient?		

2. Change in Dependent Status (complete this portion if making any changes in dependent status):			
FIRST NAME	LAST NAME	MI	SEX
Social Security #	Date of Birth	☐ Add	☐ Delete
Primary Care Physician:	PCP #	Full time student?**	
FIRST NAME	LAST NAME	MI	SEX
Social Security #	Date of Birth	☐ Add	☐ Delete
Primary Care Physician:	PCP #	Full time student?**	
FIRST NAME	LAST NAME	MI	SEX
Social Security #	Date of Birth	☐ Add	☐ Delete
Primary Care Physician:	PCP #	Full time student?**	

*** Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply.**
****For dependents 19 and over only. Please submit proof of student status.**

3. Change In Coverage (complete this portion if making any of the following changes):		
Change in Status:	Reason for Change:	What plan are you enrolled in?
☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Family ☐ Cancel Coverage ☐ Add Dependent ☐ Delete Dependent ☐ Name ☐ Address	☐ Birth - Date: _____ ☐ Death - Date: _____ ☐ Divorce - Date: _____ ☐ Marriage* - Date: _____ ☐ Other: _____	☐ Health Advantage HMO ☐ Health Advantage POS ☐ QualChoice HMO ☐ QualChoice POS ☐ Blue Cross/Blue Shield PPO

*** Please attach Marriage License; Maiden Name if applicable**

4. To Be Completed By Agency/School District:	
Agency/School District Name:	Agency/School District #:
Effective Date of Change:	Employee #:
Representative Signature:	Date:

Employee Signature: _____ **Date:** _____

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But I have a question!

Frequently Asked Questions and Answers

ACTIVE EMPLOYEES

If I'm an active employee not currently participating in the Health Insurance Program, may I enroll now?

Yes. If you want health insurance coverage this year, you must enroll during this enrollment period. Unless you or your dependents qualify under the following federal laws, you cannot enroll during the remainder of the plan year unless:

- You or your eligible dependents have lost other health insurance coverage through no action of your own.

- You have acquired a new eligible dependent through marriage, birth, adoption or placement for adoption.

NOTE: Voluntary termination from another plan does not qualify you to enroll in this plan.

Do I have to complete a new enrollment form this year?

Not if you want to remain in your current health insurance plan.

What if I want to change my health insurance plan?

Submit your completed enrollment form to your State Agency Representative. Your Agency should provide you with the forms as well as the due date, which will be sometime in October. New Primary Care Physician referrals must be obtained when changing from one insurance carrier to another.

Are the network providers in my current plan remaining the same?

There are frequent changes in every network; therefore, please check the provider directories or – for the latest network information – call the plans or visit their web sites.

Do I have to select the same PCP for my entire family?

No. Each member of your family may select a different primary care physician (PCP). In the past, QualChoice required their female members over the age of sixteen (16) to select two (2) PCP's: one for physical health and one for gynecological care. That is no longer required. Female plan members under Health Advantage or QualChoice plans can seek gynecological care without a referral if the provider is in that company's network.

May I change my PCP at any time?

Yes, but because each plan has its own guidelines, you should contact the POS or HMO plan in which you are enrolled

What is the difference between a "Pure HMO" and the POS plans offered?

A pure HMO offers no out-of-network benefits except in cases of dire emergency or special insurance company pre-authorized out-of-network referrals. An HMO requires a member to obtain a referral from their Primary Care Physician for speciality care. If referrals are not obtained from the Primary Care Physician the claim will be denied. POS plans offer an HMO benefit when an insured stays in network with a PCP referral, but also offers reduced benefits when the insured seeks specialty services without a referral.

The POS benefit is generally designed for people that want the flexibility to access health care both in-network (with PCP referral) and out-of-network without obtaining a referral from the Primary Care Physician. The POS benefit allows you to go out-of-network, just remember that 70% of maximum allowable payment is not 70% of billed charges. The POS benefit can be used for members who reside out of state also, because you can use providers that are not in the network. The HMO is not designed for members who live out of state, as there are no benefits outside the network. Most networks are only statewide. There are a few exceptions to that rule if you reside in a border city such as Texarkana, West Memphis, etc. Please contact your specific HMO carrier to determine if networks are available to you in the border cities.

What is a PPO and how does a PPO differ from an HMO and POS?

A PPO is an Indemnity Plan. In a PPO Plan, a member has a separate deductible and a separate coinsurance for both in and out of network services. If the member stays in the statewide PPO network is likely that the plan will pay a higher reimbursement than if the member accesses care outside the PPO network.

Are my child's immunizations covered?

State mandated immunizations are a covered benefit for children up to age 18. Some adult immunizations are a covered benefit. Contact your insurance plan if you have questions about immunizations.

How can my children who are in college <u>in-state</u> access my POS or HMO Plan?

Routine non-emergency medical services are paid according to "in" and "out-of-network" rules. A network provider located in the college town qualifies as "in-network," just like a hometown in-network physician. We recommend your child select a PCP in their college town. Emergency services, regardless of the provider used, are paid "in-network". Charges incurred at a school infirmary are not covered.

How can my children who are in college out-of-state access my POS or HMO Plan?

Routine healthcare benefits for college students out-of-state will be limited or non-existent and the HMO would be the least favored plan for out-of-state college students. Health care benefits are available in the POS plan, just remember that the POS benefit reimburses at 70% of maximum allowable amount rather than 70% of billed charges after deductible is met. Therefore, for a college student out of state, this plan does provide some limited benefits. Call your health insurance carrier to inquire if a guest membership is available for out of state students. The Health Advantage Point of Service, (POS) Plan may offer options for out-of-state coverage at a more affordable rate than the Preferred Provider Organization.

If my PCP pulls out of the network that I am enrolled in after the enrollment period, may I change plans?

Plan changes mid-year are rarely allowed. Only in cases of documented lack of access to providers will a mid-year enrollment be permitted. For example, in the event that a county loses all of its network providers in a particular plan, a “special” re-enrollment would permit all plan participants in that county to select another plan. The decision to allow a special enrollment comes from the Employee Benefits Division (EBD).

LIFE INSURANCE

How do I enroll in the Supplemental Life program offered by USAble Life?

New employees will have thrity (30) days from their hire date to enroll in the Supplemental Life program without evidence of insurability. You may apply for Supplemental Life even if you are not enrolled in the Health Plan. If you are currently insured by the State Employee group health plan, but have not elected Supplemental Life, you may make application by providing evidence of insurability. If you are not enrolled in the State Employee group health plan and wish to enroll in the Supplemental Life Plan you may make application by providing evidence of insurability. Please contact your State Agency Insurance Representative to obtain a Supplemental Life application.

For how much Supplemental Life may I apply?

Your may apply for either one or two (2) times your annual salary (coverage may not exceed $250,000; for Legislators/Constitutional Officers, coverages may not exceed $50,000).

COBRA PARTICIPANTS

May I change plans if I go on COBRA?

COBRA participants are eligible to change plans at "open enrollment." You cannot change plans in mid-year.

Are the same benefits offered to COBRA participants as to active employees?

COBRA participants have the same pharmacy and medical benefits as active and retired employees. Life insurance is not available to COBRA participants through this health plan. Contact USAble Life for conversion options.

FOR RETIREES - OR THOSE THINKING ABOUT RETIREMENT

(Please note: The Employee Benefits Division (EBD) has produced an "Enrollment Guide for State Retirees" in addition to this one for active employees. You may obtain a copy from EBD or on the EBD website www.accessarkansas.org/dfa/ebd

May I change my insurance plan if I retire after October 31, 2003?

Plan changes can be made only at "open enrollment" unless you have a life changing event that qualifies you for a "special enrollment" (such as marriage, divorce, death of spouse, etc.).

What if I select COBRA rather than the retirement plan?

If you select COBRA **you lose the life insurance benefit.** This benefit will not be reinstated when you go to the retirement group. EBD will bill you monthly. When you become Medicare eligible, your COBRA benefits will be terminated and you may elect coverage under the State Retiree Plan.

How will my retirement premiums be billed?

Your premium will be automatically deducted from your retirement check every month. If your retirement check does not cover the premium cost, you will receive a monthly billing from EBD showing the amount due each month and the due date.

What if I have Medicare?

As a retired insured, you are eligible to continue your state medical insurance after Medicare begins. When Medicare commences, it will become your primary coverage and claims will be filed with Medicare first. Please check with the health plan you select to determine how it coordinates with Medicare. Also, please remember that Medicare coverage is very limited. Most of your prescription drugs will be covered by your state prescription drug program.

Retirees eligible for Medicare must have both Part A and Part B.

The state health plan will pay as if you have Part B, whether you have it or not.

Complaint and Appeal Process

HMO and POS Process

Authority of Employee Benefits Division

Employee Benefits Division (EBD) shall have authority and full discretion to decide all questions arising in connection with coverage under the Plan, including interpretation of Plan language, and findings of fact with regard to any such questions.

DEFINITIONS:

Complaint. An expression of dissatisfaction either oral or written.

Appeal. A request to change a previous decision made by the Claims Administrator. Appeal as used in this Attachment A does not include appeals regarding termination of coverage. Appeals for termination of coverage are subject to the appeals procedure set out in Section 4.2.3 of the Summary Plan Description.

HOW TO SUBMIT A COMPLAINT OR APPEAL

Complaints or Appeals may be submitted in writing to your chosen Claims Administrator.

For Health Advantage:
Health Advantage
P. O. Box 8069
Little Rock, Arkansas 72203.
Attention: Appeals Coordinator

For QualChoice of Arkansas:
QualChoice of Arkansas
10825 Financial Centre Parkway, Suite 400
Little Rock, Arkansas 72211
Attention: Appeals Coordinator

Members will not suffer any sanctions or penalties resulting from submitting a Complaint or Appeal.

ORAL COMPLAINTS

A Member having a Complaint regarding any aspect of the Claims Administrator may contact a Customer Service Representative specific to the chosen Claims Administrator. For Health Advantage, 800-482-8416; for QualChoice of Arkansas 800-235-7111. The Customer Service Representative will assist in resolving the matter informally. If the Member is not satisfied with the resolution, a written Complaint may be submitted. A Member is not required to make an oral Complaint prior to submitting a written Complaint.

WRITTEN COMPLAINTS

The Claims Administrators will acknowledge receipt of a written Complaint within seven (7) working days. A thorough investigation of the Complaint will be made and the Member will be mailed a response with resolution. If the Claims Administrator is unable to resolve the written Complaint within thirty (30) working days due to circumstances beyond its control, the member will be provided notice of the reason for the delay before the 30th working day.

HOW TO FILE AN APPEAL

An appeal must be submitted in writing to the chosen Claims Administrator at the previously documented addresses and must identify a specific action or determination of the Claims Administrator for which the Member seeks an appeal. The Claims Administrator will acknowledge receipt of the appeal within seven (7) working days.

The appeal must be made within 180 days from the date of the notice of the Claims Administrator's determination that the Member is appealing. At any stage of the appeal, the Member may designate, by signed written notice to the Claims Administrator, a representative to assist in making the appeal. Any such designation shall constitute authorization for the Claims Administrator to release any information or records regarding the appeal or the Member to the designated representative.

First Level Review

A person or persons not involved in the initial determination will review the appeal. The Claims Administrator may request additional information from the member in order to review the appeal. The Claims Administrator will respond in writing within thrity (30) days after receipt of all pertinent information. If the Claims Administrator is unable to resolve the appeal within thirty (30) working days, the Member will be notified of the delay on or before the 30th working day. The time frame for resolving the appeal shall not exceed forty-five (45) working days. If the outcome is adverse to the Member, he/she may appeal to the second level.

Second Level Review

Health Advantage

If a member is not satisfied with the determination received on the first level of appeal, the member may appeal to a Second Level Review Committee. The appeal must be received within sixty (60) days of the notification of denial by the First Level Review. A committee established by Health Advantage shall conduct the second level of review within thirty (30) working days after receipt of the Member's appeal to the second level. The committee shall consist of persons who were not involved in the initial determination or First Level Review; although such person(s) may appear before or communicate with the committee. The committee will meet and make a determination of the Member's appeal. The Member has the right to appear in person, attend via teleconference, or be represented by a person of his/her choice.

QualChoice

If a member is not satisfied with the determination received on the first level of appeal, a second level appeal may be made in writing to QualChoice. A review of the second level appeal will be conducted within 30 working days after the receipt of the Member's appeal to the second level. The appeal will be reviewed by one of the plan's Physician Advisors who was not involved in the initial determination or the First Level of appeal; although such person(s) may be communicated with during the review process.

Final Level Review

If the outcome of the Second Level Review is adverse to the member, he/she may appeal to the Plan Administrator. Such appeal should be mailed to: Employee Benefits Division, Attention Appeals, State of Arkansas, Department of Finance and Administration, P.O.Box 15610, Little Rock, AR 72231-5610. The decision of the Plan Administrator will be made within thirty (30) days of receipt of the written appeal and is final and binding on the Plan and the Member.

Expedited Appeal

An expedited appeal may be requested related to a claim involving urgent or ongoing care. The request may be made by telephone followed by written confirmation or in writing. If a member or someone designated by the Member and acting on behalf of the member requests an expedited appeal the Claims Administrator's Appeals Coordinator will notify the Member or the Member's authorized representative and the member's treating health care professional of the determination of the expedited appeal in accordance with the medical needs of the case and as soon as possible, but in no case later that seventy-two (72) hours after the Appeals Coordinator receives the expedited appeal.

Authorized Representative

A Member may have one representative and only one representative at a time to assist in submitting a claim or appealing an unfavorable claim determination. An authorized representative shall have the authority to represent the Member in all matters concerning the Members' claim or appeal of a claim determination. If a Member has an Authorized Representative, references to "Member", "Your" or "You" in the plan SPD refer to the Authorized Representative.

Designation of Authorized Representative

One of the following persons may act as a Member's Authorized Representative:

1. An individual designated by the Member in writing. (The Claims Administrator may require this designation be documented on the Claims Administrator's approved form);
2. The treating provider, if the claim is a claim involving urgent care, or if the Member has designated the provider in writing. (The Claims Administrator may require this designation be documented on the company's approved form);
3. A person holding the Member's durable power of attorney;
4. If the Member is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Member by a court of competent jurisdiction; or
5. If the Member is a minor, the Member's parent or legal guardian, unless the Company is notified that the Member's claim involves health care services where the authorization of the member 's parent or legal guardian is or was not required by law and the Member shall represent himself or herself with respect to the claim.

Term of the Authorized Representative

The authority of an Authorized Representative shall continue for the period specified in the member's appointment of the Authorized Representative or until the member is legally competent to represent himself or herself and notifies the Company in writing that the Authorized Representative is no longer required.

Communication with Authorized Representative

1. If the Authorized Representative represents the Member because the Authorized Representative is the Member's parent or legal guardian or attorney in fact under a durable power of attorney, the Company shall send all correspondence, notices and

benefit determinations in connection with the Member's claim to the Authorized

2. If the Authorized Representative represents the Member in connection with the submission of a pre-service claim, including a claim involving urgent care, or in connection with an appeal, the Company/Carrier shall send all correspondence, notices and benefit determinations in connection with the Member's claim to the Authorized Representative.

3. If the Authorized Representative represents the Member in connection with the submission of a post-service claim, the Company/Carrier will send all correspondence, notices, and benefit determinations in connection with the Member's claim to the Member, but the Company/Carrier will provide copies of such correspondence to the Authorized Representative upon request.

4. The Member understands that it will take the Company/Carrier at least thirty (30) days to notify its personnel about the termination of the Member's Authorized Representative and it is possible that the Company/Carrier may communicate information about the Member to the Authorized Representative during this 30-day period.

PPO Process

How To Appeal A Claim.

1. If a claim for benefits is denied either in whole or in part, you will receive a notice explaining the reason or reasons for the denial. You may request a review of a denial of benefits for any claim or portion of a claim by sending a written request to the Appeals Coordinator of Arkansas Blue Cross and Blue Shield, A Mutual Insurance Company, P.O. Box 2181, Little Rock, Arkansas 72203-2181. Your request must be made within sixty (60) days after you have been notified of the denial of benefits.

2. In preparing your request for review, you or your duly authorized representative will have the right to examine documents pertinent to your claim. However, medical information can be released to you only upon the written authorization of your Physician. You or your representative may submit, with your request for review, any additional information relevant to your claim and may also submit issues and comments in writing. A complete review will then be made of all information relating to your claim. You will receive a final decision in writing within sixty (60) days after the receipt of your review request, except where special circumstances require extensive review. A final decision will be sent to you after no longer than one hundred twenty (120) days.

3. Subsequent to the determination of the Appeals Coordinator, you can appeal to the Plan Administrator, EBD, Post Office Box 15610, Little Rock, AR 72231.

4 The Plan Administrator acting on behalf of the Plan shall have authority and full discretion to determine all questions arising in connection with your benefits, including but not limited to eligibility, interpretation of Plan language, and findings of fact with regard to any such questions shall be conclusive and binding on the Plan and you subject to the grievance and appeals procedures as outlined in the plan SPD.

EBD
P.O. Box 15610
Little Rock, Arkansas 72231

AR DEPT OF
FIN & ADMIN
PO BOX 15610
LITTLE ROCK
AR 72231

PRESORT STD
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PERMIT 2570
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